ASSEMBLY BILL No. 119

Introduced by Assembly Member Cohn

January 13, 2005

An act to amend Section 14043.26 of the Welfare and Institutions Code, relating to Medi–Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 119, as introduced, Cohn. Medi-Cal: provider enrollment.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and pursuant to which health care services are provided to qualified low–income persons.

Existing law requires an applicant that is not currently enrolled in the Medi–Cal program, or a provider required to apply for continued enrollment, in certain circumstances, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

This bill would provide for the automatic enrollment in the Medi–Cal program as a preferred provisional provider of any physician and surgeon licensed by the Medical Board of California or osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California, who meets specified conditions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that is not currently enrolled in the Medi–Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi–Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi–Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi–Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi–Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi–Cal program shall not be subject to this section.

(b) Within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or

provider belongs. This moratorium shall bar further processing of the application package.

(c) (1) If the applicant package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 90 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission for Accreditation of Healthcare Organizations or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox–Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health

and Safety Code; the Knox–Keene Act) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox–Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the Healthcare Integrity and Protection Databank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(d) Within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (c), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify any additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi–Cal beneficiary, within the

applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(e) (1) If the application package that was noticed as incomplete under subdivision (d) is resubmitted with all requested information and documentation, and received by the department within 35 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (d).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (d) is not resubmitted with all requested information and documentation and received by the department within 35 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi–Cal program.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi–Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(f) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks,

preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspections, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi–Cal program.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for three years.

(g) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a separate provider number shall be issued for each location for which an application package has been approved. This separate provider number shall be used exclusively for the location for which it is issued, unless the practice of the provider’s profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider’s business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(h) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi–Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a) may continue to submit claims under an existing provider number for services rendered at the new location until the application package is approved or denied under this section, and shall not be subject, during that period, to deactivation of the provider's provider number, or be subject to any delay or nonpayment of claims as a result of the use of the existing provider number for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations.

(i) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(j) (1) Notwithstanding any other provision of law, any applicant or provider who meets all of the following criteria shall be automatically enrolled as a preferred provisional provider:

(A) Is enrolled in good standing in the federal Medicare Program.

(B) Has submitted a Medi–Cal application form with proof of participation in the Medicare Program.

(C) Holds a current, unrevoked, unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(D) Does not have any adverse entry in the Healthcare Integrity and Protection Databank.

(2) An applicant or provider enrolled as a preferred provisional provider under this subdivision shall be granted preferred provisional status for a period of no longer than 18 months.

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